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LITTRE'S UMBILICAL HERNIA †

Case Report

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Two years ago the author reported on the subject of "Right Paraduodenal Hernia," adding the forty-seventh case to the literature of that subject. A few months ago we encountered a case that presented an unusual and perhaps unique picture of one variety of the condition known as Littre's hernia.

In 1700, Alexis Littre recorded two cases of inguinal hernia in which an intestinal diverticulum or pouch of some sort was the sole occupant of the sac. The possibility of this condition had been suggested first following an autopsy in 1683 by Frederik Ruysch, a famous Dutch anatomist and atlas maker. Littre described these pouches as secondary formations; he thought they resulted from traction on the part of the gut within the sac and hence regarded them as partial enteroceles. Lesions of this latter type were accurately described in 1777 by August Gottlieb Richter in a treatise on hernia which is still an acknowledged classic, and this type of hernia—partial herniation of the anti-mesenteric portion of the gut—is today still catalogued as a Richter's hernia though it had been observed earlier (1772) by Johann Casper Lavater.

In 1809, Johann Friedrich Meckel** was the first to classify the different varieties of

intestinal diverticula. The most important of these and the one to which his name has been given, is that which represents an incomplete obliteration of the omphalomesenteric or vitelline duct. With this diverticulum situation clarified, a review showed that the lesion which Littre had described over a century before was a Meckel's diverticulum alone in a hernial sac. Riecke, having observed a strangulated femoral hernia of Meckel's diverticulum in 1834, was the first in 1841 to suggest calling them Littre's hernias.

Considerable confusion exists in the literature over these three clinical entities: (1) Richter's hernia—a partial enterocele; (2) Littre's hernia—a hernia of Meckel's diverticulum alone, and rarer than (3) and (3) mixed Meckel's hernia—a hernia of Meckel's diverticulum, plus gut or omentum, or both.

Just why Littre's should be rarer than Meckel's nobody has explained. Perhaps it is due to the fact that a diverticulum has no propulsive or expansive characteristics, whereas gut and omentum have both. The chances are the gut or omentum arrived in the sac first and the diverticulum followed, not by adhesive but by cohesive traction.

Speaking of confusion, Moschowitz, in Johnson's "Operative Therapeutics" (1915), clearly distinguishes between a Richter's hernia and a Littre's hernia; whereas Stone, in Lewis' "Surgery" (1929), shows an illustration labelled "Littre's or Richter's Hernia" (which is definitely a Richter's hernia), and he repeats the statement in the text. It is unfortunate that such a popular reference work carries the implication that a Littre's hernia and a Richter's hernia are one and the same thing.

As to Littre's hernia, Babcock defines it as "a sac containing a blind diverticulum only, such as Meckel's diverticulum or the appendix vermiformis," whereas the blind

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** This Meckel, according to Garrison, one of a famous medical family. His grandfather, of the same name, graduated from Goettingen in 1748, at the age of twenty-four, his thesis being on the (Meckel's) sphenopalatine ganglion of the fifth cranial nerve. Three years later he was Professor of Anatomy, Botany and Obstetrics (*sic!*) at Basle. His father, Philipp Friedrich Theodor Meckel, graduated from Strassburg in 1777, at the age of twenty-one, his thesis being on the inner ear, and two years later he was Professor of Anatomy and Surgery at Halle. His brother, August Albrecht Meckel, at thirty-one, became Professor of Anatomy and Forensic Medicine at Bern. Our Meckel became Professor of Pathology, Comparative Anatomy and Embryology at Halle. Thus this family, in three generations, produced four professors, all before they had passed their thirty-first year.

diverticulum that Littre described was a vitelline duct vestige and not the appendix, though this is another vestigial organ. Keeley states that the sac may also contain "small or large intestine, and/or omentum," and Watson, an acknowledged authority on hernia, says it "may be accompanied by small intestine . . . or omentum alone," a statement reiterated by DaCosta. However, Weinstein's recent paper (December, 1938) on Littre's femoral hernia brings us back again to the original basis when he says "that the title of Littre's hernia is applied only if the diverticulum is of Meckel's type, and is the sole occupant of the hernial sac."

It is not our purpose here to go into lengthy descriptive details concerning Meckel's diverticulum, as Goodman's excellent article covers the ground thoroughly. Suffice it to say that normally the vitelline duct begins to atrophy at the seventh week of fetal life, is completely obliterated by the twelfth week, and at birth no remnant is visible. Failing to perform according to schedule, there may be present at birth anything from a mere nubbin of a closed pouch (generally on the antimesenteric border of the gut, generally without a mesentery, and at a point 12 to 36 inches from the ileocecal valve) to a continuous open tube extending from the ileum to the umbilicus and discharging feces. Consequently, the shape and size, and the mobility or fixation of Meckel's diverticulum varies within quite large limits.

A Meckel's diverticulum is subject to all the lesions that obtain in other parts of the gut: inflammation, ulcer, hemorrhage, foreign body, tumor, obstruction, strangulation, gangrene, torsion or volvulus, intussusception (in approximately 25 per cent of the reported cases), and herniation (in another 25 per cent). Herniation of the mixed Meckel's type or of the true Littre's type is possible at any of the sites of external herniation of the abdomen, and the following varieties have been reported: inguinal, femoral, umbilical, ventral (incisional), crural and sciatic. We could find no record of any case of the following types: spontaneous ventral, diaphragmatic, obturator or lumbar. Of the many possible types of internal herniation only one case has been recorded, a retrocecal hernia.

Littre's own description of his cases can, after more than 200 years, be read today without modification other than the knowledge that he was describing a hernia of Meckel's diverticulum and not, as he supposed, of what is now termed a Richter's hernia. Witness his accurate remarks on the diagnostic features, as given by Mason:

"The diagnostic signs, making this type of hernia recognizable before the operation, are:

"1. The patient goes to stool during the whole course of the illness as, the intestinal canal being uninterrupted, the excrements are at perfect liberty to pass from one end to the other.

"2. The patient has no hiccup, or very occasionally.

"3. He does not vomit, at least by comparison less frequently than in ordinary herniae. The vomitus is never fecal matter.

"4. The patient's belly is never fat, stretched or full of wind as in ordinary herniae.

"5. The tumor in the groin is formed more slowly and never becomes so large.

"6. The inflammation, fever, pain or other symptoms which may accompany this peculiar kind of hernia, are less severe and take longer to manifest themselves than in other herniae.

"The diagnostic signs which make this particular hernia recognizable during the operation are:

"1. In ordinary cases of hernia, the entire circumference of the intestinal body is engaged in the hernial sac. In this hernia there is only one part in the sac.

"2. The portion of the intestine which forms an ordinary hernia is found doubled in the shape of an arc in the sac. In this particular kind (which concerns us), this portion is single, situated perpendicularly and terminated by a very distinct end.

"3. An ordinary hernia is often formed by intestine and omentum together. This particular kind is always made by the intestine alone."

Operation on an uncomplicated Meckel's diverticulum has a mortality rate slightly above that of appendectomy, i. e., 3 to 5 per cent. If the diverticulum is diseased but not

herniated, the rate runs as high as 35 to 40 per cent. If the diverticulum is diseased and is herniated, the operative mortality extends from 45 to 50 per cent.

In diverticular hernia, the inguinal variety is commonest, being two and one-half times as frequent as the femoral or the umbilical types. Following the rule in simple hernia, in the femoral variety females outnumber the males 3 to 1; whereas in the inguinal variety exactly the reverse is true. In both of these the majority are on the right side, and most of the cases are in adults and the middle-aged. (Parenthetically, we might add that Richter's hernia is commonest in the femoral region.) In the umbilical variety sex is stated so infrequently that no reliable figures are available. Age, however, is definitely a factor, over 85 per cent being found in the newborn or in very young infants.

There is a marked discrepancy between the anatomical and the surgical occurrence of Meckel's diverticulum, due to the fact that the pathologist explores the entire abdomen, while the surgeon usually explores only a limited area of the abdomen. Anatomically, Meckel's diverticulum is found in $\frac{1}{2}$ to 2 per cent of humans, according to various post-mortem observations. The surgical incidence seems to be considerably less, about one-tenth, and varies from one case in 700 laparotomies at the Mayo Clinic, to one case in 450 at the Vanderbilt University Hospital, to one case in 400 at the New York Post-Graduate Hospital, an average of one case in 500 laparotomies. Further, Forgue and Riche, in 1907, analyzing 600 cases of Meckel's diverticulum, found that fifty-two (8.7 per cent) or about one in twelve occurred in hernias. On this basis one might anticipate encountering some type of Meckel's hernia once in 6,000 laparotomies. Finally, our own tabulation shows that 20 per cent of Meckel's hernias are umbilical, and at this rate one might anticipate encountering a Meckel's umbilical hernia once in 30,000 laparotomies, surely an astronomical expectancy. True Littre's hernias are even rarer.

TABLE I
REPORTED CASES OF MECKEL'S DIVERTICULUM
IN A HERNIA

Type	Summary			
	Gray 1934	Bird 1941	Total	Per Cent
Inguinal	89	6	95	52.19
Femoral	33	4	37	20.33
Umbilical	37	1	38	20.88
Ventral (incisional)....	0	1	1	0.55
Crural	0	1	1	0.55
Sciatic	1	0	1	0.55
Retrocecal	1	0	1	0.55
Not stated	8	0	8	4.40
Total	169	13	182	100.00

Simple congenital umbilical hernia is rare enough, and occurs about once in every 10,000 births. Such a hernia, containing a diverticulum, is considerably rarer. The number of cases of Meckel's diverticulum in a hernia, tabulated up to February, 1934, by Gray, was 169, of which only 37 were of the umbilical variety. To this 169 we have been able to add twelve non-umbilical cases, and our present umbilical case, the first since 1928, and which makes the thirty-eighth case to be reported. Several of the cases tabulated were of the mixed Meckel's type. We have not yet been able to determine the exact number of true Littre's hernias on record.

CASE REPORT

The patient was a male, colored baby, born of an eighteen-year-old unmarried mother, para II, on March 17, 1941, at the Wilmington General Hospital. The baby weighed 6 pounds $12\frac{1}{2}$ ounces, and appeared to be physically normal in all respects. There was no apparent enlargement (Fig 1) of the umbilical end of the cord, which was tied off in the usual manner. On the third day the cord was red and had a slight purulent discharge, and on this day the Pediatric Department was called in to supervise the feedings, etc. On the fourth day the cord sloughed off (Fig. 2), and later that day some feces were passed via the umbilicus. On the fifth day

a loop of gut or a pouch began to present at the umbilicus (Fig. 3), and by the sixth day

diameter and extending 2 inches to end blindly. The extra-abdominal portion of the sac

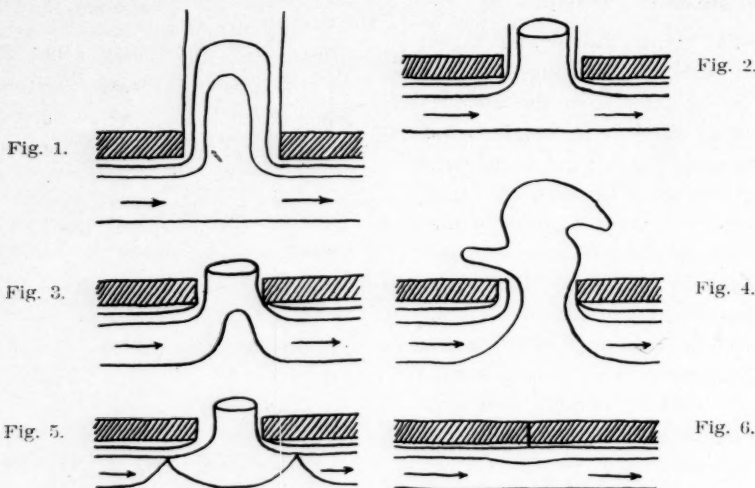


Fig. 1. The anatomy at birth, showing an apparently normal cord but containing an unsuspected hernia sac into which protrudes a Meckel's diverticulum.

Fig. 2. Fourth day, showing the cord, hernia sac and the diverticulum sloughed off at the point of ligation.

Fig. 3. Fifth day, showing the beginning of the eversion of the mesenteric border of the gut through the opening in the diverticulum.

Fig. 4. Seventh day, showing the eversion completed and the main pouch with its two secondary pouches. The presenting surface was, of course, mucosa. At operation, on the twenty-fourth day, the two lateral openings, mistaken for fistulas, were sutured.

Fig. 5. At operation after the eversion was reduced it was discovered that the two sutured "fistulas" had been converted into two complete obstructions. The eversion was then re-established, as in Figure 4, and the offending sutures removed.

Fig. 6. The operation completed, showing the lumen of the gut approximately normal in diameter.

this extended $3\frac{1}{2}$ inches on to the abdominal wall.

On the seventh day the Surgical Department was called in consultation. The weight was then 5 pounds 15 ounces. Our examination showed a pouch of intestine on the abdominal wall (Fig. 4) some 5 inches long and $2\frac{1}{2}$ inches in diameter with a blind end. From the right side of this pouch was a secondary pouch, arising $1\frac{1}{2}$ inches from the umbilicus with a diameter of $\frac{1}{2}$ inch, and extending 2 inches to end blindly. From the left side near the distal end of the main pouch was another secondary pouch nearly 1 inch in

(peritoneum) was missing. On palpation the pouch felt as though it contained omentum; there were no gurgles. The neck of the pouch was adherent to the umbilical ring, which was $\frac{3}{4}$ inch in diameter, and from the left side of the ring feces were passing through a small opening. The main pouch could not be reduced because of edema and the adhesions, nor could it be pulled out further. The flow of feces accounted for the progressive loss of weight and the absence of symptoms of obstruction; as a matter of fact, stools were also passed through the rectum daily both before and after operation.

The surface of this trilocular pouch appeared to be mucosa but a differentiation between mucosa and peritoneum with massive granulations could not surely be made. However,

to wait a few days in an effort to build up the patient. Unfortunately, the baby lost ground steadily and on the twenty-fourth day the weight was only 4 pounds 13¼ ounces,

TABLE II
REPORTED CASES OF MECKEL'S DIVERTICULUM IN A HERNIA
Tabulation

Report No.	Author	Date	Cases	Inguinal	Femoral	Umbilical	Ventral (Incisional)	Crural	Sciatic	Retrocecal	Not Stated
1	Pabst	1910	123	66	24	25	0	0	0	1	7
2	Wellington	1913	27	14	2	10	0	0	0	0	1
3	Burianek	1913	1	0	1	0	0	0	0	0	0
4	Harf	1919	1	0	1	0	0	0	0	0	0
5	Quenu	1921	1	1	0	0	0	0	0	0	0
6	Bettman	1921	1	1	0	0	0	0	0	0	0
7	Ludbrook	1922	1	0	1	0	0	0	0	0	0
8	Brodnax	1924	1	0	0	0	0	0	1	0	0
9	Lanman	1924	1	1	0	0	0	0	0	0	0
10	Littler	1924	1	0	1	0	0	0	0	0	0
11	Harrington	1926	1	0	1	0	0	0	0	0	0
12	Bianchi	1927	2	1	0	1	0	0	0	0	0
13	Oliva	1927	1	1	0	0	0	0	0	0	0
14	Sicard	1928	1	0	0	1	0	0	0	0	0
15	Reid	1928	1	1	0	0	0	0	0	0	0
16	Pollidori	1930	2	2	0	0	0	0	0	0	0
17	Sweet	1930	1	0	1	0	0	0	0	0	0
18	Donati	1931	1	0	1	0	0	0	0	0	0
19	Gray	1934	1	1	0	0	0	0	0	0	0
20	Sinclair	1922	1	0	1	0	0	0	0	0	0
21	Folliasson	1932	1	1	0	0	0	0	0	0	0
22	Mason	1933	1	0	1	0	0	0	0	0	0
23	Ittzes	1934	1	1	0	0	0	0	0	0	0
24	Bettinelli	1935	1	1	0	0	0	0	0	0	0
25	May	1935	1	1	0	0	0	0	0	0	0
26	Rodnaev	1936	1	1	0	0	0	0	0	0	0
27	deTroyer et duBourguet	1937	1	1	0	0	0	0	0	0	0
28	Keeley	1937	1	0	0	0	1	0	0	0	0
29	Quiri	1938	1	0	0	0	0	1	0	0	0
30	Weinstein	1938	1	0	1	0	0	0	0	0	0
31	Ringo & Charlton	1940	1	0	1	0	0	0	0	0	0
32	Bird	1941	1	0	0	1	0	0	0	0	0
Total			182	95	37	38	1	1	1	1	8
Per cent			100	52.19	20.33	20.88	0.55	0.55	0.55	0.55	4.40

Tabulation of Reports Nos. 1 to 19 after Gray; Nos. 20 to 32 by the author.

No. 20, Sinclair's case, contained also a Richter's hernia, the only combined case in the literature.

a tentative diagnosis was made as follows: congenital umbilical hernia, sac contents either cecum and appendix or Meckel's diverticulum; fecal fistula. Operation was advised and accepted by the family. In consultation with the pediatrician it was decided

a loss of one-third of the birth weight, and operation was decided upon as a matter of necessity.

On April 10, 1941, under novocain anesthesia the abdomen was opened below the umbilicus where nothing was noted. On en-

larging the incision up to the umbilicus two loops of ileum seemed to enter the ring from within. The left external opening through

opening made by the sloughing off of the top of the cord and of the parietal peritoneum. On passing a soft catheter proximally and

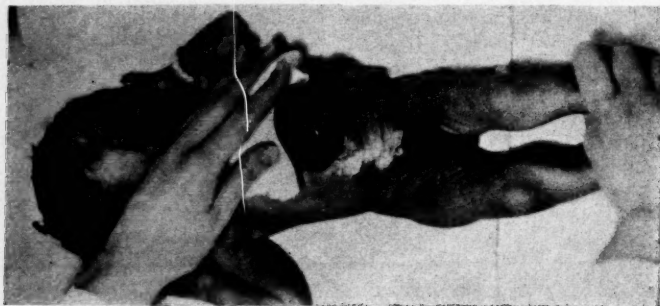


Fig. 7. The patient in the recumbent position.

which feces were still passing was then sutured, as was a similar opening on the right side, following which the neck of the pouch was freed of its adhesions to the ring. Then

distally it was found that the two sutures we had placed had very neatly closed (Fig. 5) the lumen at both points. The eversion was then re-established, the two sutures removed and the pouch inverted once more.

The picture then was that of a Meckel's diverticulum with a base of $1\frac{1}{2}$ inches and a height of $\frac{3}{4}$ inch to the opening made by the sloughing. How much greater the original height had been is a matter of conjecture, probably another $\frac{3}{4}$ inch. The remaining part of the diverticulum was then excised, the ileum sutured longitudinally with two rows of fine silk, leaving a lumen of approximately normal diameter. The diverticulum was 12 inches from the ileocecal valve. The umbilicus was then excised and the hernia repaired quickly by longitudinal suturing (silk, Pagenstecher, dermal) without drainage (Fig. 6). Just before closing the peritoneum 150 cc. of Ochsner's papain solution was run into the abdomen as a protection against colon bacillus infection. For the final stages of the closure a few whiffs of vinethane were given. The patient was returned to the ward in fairly good condition.

The pathological report stated that the diverticulum contained no gastric, duodenal, pancreatic or other heterotopic tissue.

Postoperatively, the baby did fairly well for three days, gaining 5 ounces in weight. On the fourth day it developed a pneumonia in the left lower lobe and succumbed on the sixth day at the age of thirty days. The autopsy, in addition to the left pneumonia,



Fig. 8. The patient in the upright position.

on pushing the main pouch back into the abdominal cavity it suddenly turned outside in, and it was apparent that it had been the mesenteric side of a Meckel's diverticulum completely everted by passing through the

showed a beginning pneumonia in the right lower lobe. There was a moderate degree of plastic peritonitis at the operative site, which probably represented an infantile reaction to the papain solution, the adhesions of which were easily separated. Also, the liver showed extensive fatty degeneration.

SUMMARY

1. Meckel's diverticulum in a hernia is discussed and the recorded (182) cases tabulated to date.

2. Littre's hernia is differentiated from the lesions with which it is confused.

3. A new case of the umbilical variety of Littre's hernia is reported, and its operative rarity estimated.

4. The case presented, the thirty-eighth in the literature, is perhaps unique.

CONCLUSIONS

1. Hernia of the umbilical cord is so rare that its possible presence is usually not suspected at delivery.

2. The sequelae of such an unsuspected hernia may be fatal.

3. In the absence at birth of physical findings indicating such an anomaly, there is no sure or even satisfactory method of preventing an accident.

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THE DOCTOR OF MEDICINE AND HIS RESPONSIBILITY †

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Members of the North Central Medical Conference, representing the states of North Dakota, South Dakota, Minnesota, Wisconsin, Nebraska, and Iowa, have entrusted me with the responsibility of addressing this National Conference on Medical Service concerning medical problems that are of both local and national interest.

It is the duty of every doctor of medicine to prevent illness, to supply adequate medical care to those who are ill, to perpetuate the science of medicine, and to encourage medical investigation. It is true that the average physician would prefer to go unregimented among his sick and administer to their needs, irrespective of race, color, creed, or financial status, rather than busy himself with administrative and political problems. However, since the courts have ruled that group health is a business and have found that medical societies are guilty of restraining trade when attempting to maintain the standards of the practice of medicine, a challenge has been issued to the medical profession: Is there a necessity for lay groups and the Federal government to take over the control of the practice of medicine?

Has the science of medicine reached its zenith? Have the men and women of medicine become so decadent that they are unable to assume their responsibilities? Are the doctors of medicine no longer able to conduct their practice without government control? Do they lack ability to appreciate their problems? Or are they incapable of constructive leadership in the solution of the numerous responsibilities that are confronting the medical profession today? The reply is, "No."

The science of medicine has been nurtured by men and women who have advanced the knowledge of relieving pain, correcting deformities, lowering infant mortality, prolong-

ing life and preventing illness by sanitary and public health measures. This progress must continue if civilization is to survive.

The medical profession is conscious of social and economic changes and stands ready to co-operate with, and offer leadership to, state and federal agencies in the solution of medical problems. It further believes that better medical service can be rendered by offering advice and leadership to welfare agencies than by serving as a tool under political bureaus.

The medical profession recognizes the necessity of state and federal control of communicable diseases and medical services to inmates of state and federal institutions. It appreciates its responsibility to the Armed Forces and expects to supply the needed personnel. It is willing to co-operate with welfare agencies in providing adequate medical care for the low income and indigent groups of the population; but in providing this care, it believes that the medical service is augmented when the patient-physician relationship can be maintained by permitting the patient, whenever possible, to choose his own physician. In order to protect the public from worthless, so-called medical procedures and unnecessary operations by unscrupulous individuals, it likewise believes that high standards of medical education and practice must be maintained. This applies not only to the practice of medicine in the office; it applies to the practice of medicine in the humble home or in the most modern hospital.

Although medical education begins in the medical school, it is never completed as long as the physician continues his practice. Medical schools have adopted standards of education and have required certain courses of study in order that the public might avail itself of the best practices of medicine. Medical licensing boards have further protected the public by requiring of their candidates for licensure prescribed courses of study. State laws governing the practice of medicine and conduct of physicians further protect the public from irregular practices and charlatans.

Medical societies, county, state, and national, have been organized to further the

† Read at the National Conference on Medical Service, Chicago, February 14, 1943.

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education of the physician by acquainting him with the advances and new discoveries in the science of medicine. They likewise serve as administrative units in the consideration and solution of medical problems. It is obvious that the responsibilities of the respective state organizations are greater than those of the county organizations, and that the national organizations is charged with greater responsibilities than those of the state organizations. However, it is also obvious that the activities of all groups must be integrated if medical problems are to be solved effectively. In some states, such as Minnesota, the administrative and the legislative bodies have the confidence of the medical profession. Likewise the medical profession has the confidence of the state administrative and legislative bodies. This confidence has made it possible for representatives of both groups to attack and solve the medical problems which are of mutual interest.

The national organization, through its respective bodies and committees, has conducted an excellent program in furthering medical education. It has crystallized the standards of medical education for the medical student as well as for the practitioner of medicine; it has investigated the claims of new and non-official remedies, foods and therapeutic measures and has further protected the public by approval or disapproval of the articles investigated. It has taken active steps through its Procurement and Assignment Committee in providing medical men for the Armed forces, without robbing communities of adequate medical personnel and has made provisions for relocation of physicians where more medical service is needed. It has acquainted the public with the important role that the science of medicine plays in their daily lives, but apparently it has not gained the confidence of the national administrative and legislative bodies that some of the state medical societies have attained. The National Physicians' Committee has made some progress in acquainting the public with the necessity of medical science, but it too had not obtained the confidence of the national administrative and legislative branches of our government. Therefore, the recent court decision has emphasized the weakness of conducting a pro-

gram of education to acquaint the public, the administrative and legislative bodies of certain states, and the national institutions with the important function of the science of medicine in our civilization. It is our duty, as physicians and citizens, to assure those in administrative position and legislative bodies that we are familiar with the social and economic changes that have thrown greater responsibilities on the medical profession and that we stand ready to co-operate with these agencies in offering leadership in the solution of the numerous problems which nonmedical personnel are trying to solve.

The chief medical problem that concerns doctors of medicine and welfare agencies is that of providing adequate medical care to those who are financially unable to procure this care. This group includes those who are indigent and those with low incomes. Medical care, in its true sense, embraces more than emergency treatment for a particular illness, since it should include a rehabilitation program, such as the correction of deformities and ailments that impair the efficiency of individuals. The rehabilitation program also should include adequate and proper diets, physical training, recreation, protective clothing and housing. In most of the cities the indigent are provided with proper medical care through the charity hospitals, where competent physicians give of their services. This same group in the rural districts is not always so fortunate, since local welfare boards are reluctant to provide this care. It is in these situations that the physicians have been overburdened in assuming all of the responsibilities in providing the necessary medical care. Prior to the more recent economic changes, physicians were willing to assume this obligation because those who could afford to pay for professional services attempted to meet their obligations. However, as a result of the recent social and economic changes, the Government has taken over more and more control of the civilian's activities, and those with moderate and low incomes have been less willing to assume their obligations of medical care and are insisting that it is the Government's duty to provide medical care and that it is the indi-

vidual's privilege to squander his extra change.

The problems of this group cannot be solved by physicians alone or by federal, state, and local welfare agencies alone. Ours is a joint responsibility. Conscientious leadership by physicians working in co-operation with county, state and federal agencies can and will bring forth a solution of the problem. Medical service must be rendered, and the physician is willing to give a good portion of his services. But the government must provide reasonable funds for the care of its indigent, as it must provide for catastrophic illness in the low income group. Nevertheless, those who come within the low income group should likewise be made to realize that they too owe a responsibility to their local, state and federal governments and should be encouraged and advised in budgeting their income and expense.

Industrial compensation has accomplished much in providing proper medical care and the necessities of life, during illness, for those employed in industrial institutions. However, there still remain a large group of individuals who receive moderate or low incomes and are desirous of securing the assurance of adequate medical service in the event of illness. Insurance companies have offered this protection through policies covering accident and illness disabilities, but again this protection only partially solves the problem, since many an insuree expects more for his premium than the insurer is able to give. In several states medical societies have attempted to develop medical service plans whereby the insuree may purchase from the doctors within the group full medical protection or medical protection for unexpected, serious illnesses. In some states under the farm security program, experimental medical service plans are being tested out by use in an attempt to find the solution of the problem of supplying medical care to the farmers and their families who are being rehabilitated. In some states physicians are hired to render medical service to indigent and co-operative groups. Even though physicians, welfare agencies and low income groups are struggling with the problems of medical service plans, as yet a satisfactory plan for all classes

has not been developed. The recipients expect more than the vendors can supply for the premiums paid.

These controversies give rise to discussions on the necessity of compulsory medical insurance. Should such a program evolve, results would be disappointing from the patient's as well as the physician's points of view if placed under the control of political bureaus, and the patient would be deprived of his free choice of physician.

Therefore, we as physicians believe that a more equitable solution of the perplexing medical problems referred to will be reached if we are permitted to consult and advise administrative officials, legislative bodies, and welfare agencies, since we are more familiar with the medical needs of our respective communities than are those who have casual knowledge of the medical necessities.

It is befitting to quote the statement found in the opinion written by Justice Miller, of the United States Court of Appeals, of the District of Columbia, in the case of the United States of America versus the American Medical Association, and the case of the United States of America versus the Medical Society of the District of Columbia. (The italics are mine.)

"It may be regrettable that Congress chose to take over in the Sherman Act the common law concept of trade, at least to the extent of including therein the practice of medicine. Developments which have taken place during recent decades in the building up of standards of professional education and licensure, together with self-imposed standards of discipline and professional ethics, have, in the belief of many persons, resulted in substantial differences between professional practices and the generally accepted methods of trade and business. As we pointed out in our earlier decision, the American Medical Association and other local medical associations have undoubtedly made a profound contribution to this development. *However, our*

task is not to legislate or declare policy in such matters, but rather, to interpret and apply standards and policies which have been declared by the legislature. That Congress did use the common law test there is no doubt. That Congress was not otherwise advised was perhaps because of the failure of the professional groups to insist upon the distinction and to secure its legislative recognition."

Does the medical profession of this country need a stronger invitation, or a more direct challenge to take an intelligent, helpful and fair stand in the enactment of legislation that not only concerns the public welfare but the welfare of medicine itself? Does not the medical profession of this country, as citizens and taxpayers, have a right to express its opinion in these matters before legislation is enacted and rules and regulations adopted by some bureau? I do not share the opinion that the time for the medical profession to speak up is after such things have taken place. Neither do I have the opinion that Congress would be resentful of intelligent, courageous and fair advice on such matters. What better proof can be asked than the quotation from Justice Miller's opinion that the Court is not responsible for the absence of advice from the medical profession when Congress is drafting a law?

It is not the purpose of this paper to criticize the efforts of our national medical organizations nor to criticize the efforts of the National Physicians' Committee, but it is the desire of the members of the North Central Medical Conference to express a wish that a more active program be conducted to acquaint the public, government officials, and legislative bodies with the necessity of medical science and the important role it plays in our civilization. It is essential that we as physicians dispel the fear that government administrative agencies and legislative bodies have of our medical organizations and that they be assured of our cooperation in solving the social and economic problems that confront us as a nation.

The functions of acquainting the public on matters of medical interest, assisting bureaus in formulating plans on medical care and offering constructive advice on proposed medical legislation rightfully belong to the national organization known as the American Medical Association. They could be assigned to the National Physicians' Committee, or they might even be undertaken by unifying the activities of the various state committees on public policy and legislation. Representative committees could be appointed for each of the component societies, county, state, and national. These could all be so integrated that national opinion and advice could be obtained and made available for committee hearings on legislation within a few hours' time. Through the national, state, and county committees the entire profession could be informed of proposed medical legislation. Thus, the local constituents of the respective state and federal legislators could express their views before legislation is enacted. Some states already have medical advisory committees from each county. They also have state medical committees on public policy with a physician as part-time executive chairman, assisted by legal counsel. A national committee constructed on the same plan as these state committees would have to be created. A physician who has practiced medicine should be chosen as the executive chairman. Both he and his legal counsel would need to be stationed in our national capital. The expense of the national committee on public policy could be financed by one of three agencies, the American Medical Association, the National Physicians' Committee, or the respective state organizations bearing the expense jointly. It would appear more equitable if each physician would be assessed each year for the specific purpose of maintaining a national committee on public policy and legislation.

Our problems are not unlike those of dentists and hospital associations. Therefore, unified effort of medical, dental, and hospital associations should further the welfare of the patient.

SOCIAL INSURANCE

In a recent address before the Kings County Medical Society,¹ Mr. Louis H. Pink said in part, commenting on the *Beveridge Report*:

"Sir William makes it clear that his plan for freedom from want is based upon very important prior considerations, which have not been sufficiently stressed in this country.

"That the world after the war is a world in which the nations set themselves to cooperate for production and peace, rather than to plotting for mutual destruction by war, whether open or concealed.

"That the readjustments of British economic policy and structure that will be required by changed conditions after the war should be made, so that productive employment is maintained."

"Increasing the number of persons covered and the amount of benefits, provided such broadening is based upon long-term ability to pay, need not be postponed until after the war. But, standing alone, increased insurance coverage cannot provide freedom from want. Security must be based first of all upon a different kind of world. The nations must cooperate with each other so that economic benefits will be available to all and trade may flow freely. The standard of living must be increased, not only in one or two nations, but generally throughout the world. We must, through encouragement and stimulation of private initiative and worth-while public enterprises, see to it that people are fully employed in productive effort. If these two objectives are not accomplished, it is idle to talk about any considerable extension of social security as a permanent plan.

"Why is so little thought and planning given to these basic necessities and so much to the mere passing of laws which will extend compulsory insurance benefits? Are we not getting the cart before the horse?

"Social insurance cannot create wealth; it can only distribute it more equitably. Any politician can propose a plan for extending social security, but only a statesman can erect it upon the base of full employment and international economic cooperation. We should increase our social security benefits and extend them as rapidly as we can, but there is danger that if we get this intricate machine speeding too rapidly and have not sufficient oil, we may burn out the bearings."

It is well that so qualified and experienced a man as the former State Superintendent of Insurance, now president of the Associated Hospital Service, should emphasize these points. We hope he will continue to hammer them in, and we believe that every physician will lend a hand to assist him.

Commenting on his address, the *Westchester Medical Bulletin*² said editorially:

"He cautions those who would apply the British plan to the United States, to consider the existing differences in wage scales in the two coun-

tries; to remember 'the sincere attachment of our people to the preservation of reasonable political power and authority in the state and local communities'; and to make allowance for the desire of Americans to voluntarily provide for themselves and their families.....

"One cannot buy the experience of twenty years in two years; hence, Mr. Pink cautions us against listening to those who suggest that we can make up for lost time, skip over all the evolutionary steps, and improvise a mature and workable system of social insurance surpassing in excellence anything developed in Europe after decades of painstaking experiment.

"Even when Mr. Pink was our State Superintendent of Insurance, he was well known as a proponent of voluntary efforts in the field of social insurance.

"In our opinion, it is foolhardy for one to appose the trend toward social security just as it is foolhardy, if not indeed suicidal, to oppose the principle of collective security among nations. But, as Mr. Pink so admirably states, 'social insurance cannot create wealth; it can only distribute it more equitably,' and we would do well to put first things first, by first making secure the social and economic bases for the untrammelled creation of wealth before devoting all our attention to the task of spreading it around."

Unless such common sense as that of Mr. Pink is heeded we are all likely to find ourselves in the situation of Motteux, of whom Rabelais wrote: "He left a paper sealed up, wherein were found three clauses as his last will: 'I owe much; I have nothing; I leave the rest to the poor.'"

Editorial, *N. Y. St. J. M.*, April 15, 1943.

"There Are Such Things"

Aberdeen, Md., Jan. 19th, 1942.

Dr. X. Y. Blank,
Wilmington, Dela.

Dear Dr. Blank:

When I left Wilmington in 1915, I also left behind a bill that you had against me for attention to my wife in 1914. As I recall it was for \$50.

I have never been in a position until now when I could pay several of such debts, but now that I am, I want to settle them regardless of their age.

My reason for not sending you a check with this letter is because I do not have your street address, and I do not want the letter with check to go astray.

Will you please let me know, if this letter reaches you O. K., your street address, and whether or not my memory in this matter is correct.

Very truly,

A. B. C.

January 25, 1943.

Mr. A. B. C.,
Aberdeen, Maryland

Dear Mr. C.:

Thank you for your letter of January 19th. It is most gratifying nowadays to find people as honest as you. I shall greatly appreciate your remittance of \$50.

With kindest personal regards.

Yours very truly,

X. Y. Blank, M. D.
Street.

¹ February 16, 1943.
² March, 1943.

Editorial

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CAPITALISM DESIRABLE

Somehow we have little fear of communism taking hold in our country. No communistic form of government has ever been successful. When put to the test in Russia, it resulted in the control of the government by a few who held their power through a system of force and terrorism just as undesirable as the Czarist regime. The fine showing of Russian defense must be attributed to the love of the Russian for his homeland rather than to the type of government.

Neither is a purely socialistic form of government with the elimination of capitalism ever likely to meet the approval of American citizens. The socialistic party in Germany met the same fate as communism in Russia, with the usurpation of power by a few brigands led by a psychopath which promises to result in the destruction of the country as well as the rest of Europe.

The elimination of capitalism will never

meet with the approval of employer or labor unions. It is safe to say that as long as the majority of citizens in any country have private possessions to lose, there is no danger of revolution either violent or peaceful. Following 1929 the terms "capitalist" and "capitalism" were frequently referred to in a disparaging manner. Capitalism was blamed for the crash in 1929 and was considered by some a failure. Only shallow thinking fails to realize that any business enterprise requires savings or capital for its initiation. Anyone with a few hundred dollars saved is, strictly speaking, a capitalist. It takes savings and capital to make jobs and it is high time the opprobrium be removed from the word "capitalist." It is the capitalistic form of social order which has been the driving force that has made living in America better than in any other country.

The ambitious American who wants to accomplish things in a big way will want to continue our capitalistic form of society. Thinking leaders of unions know there would be no arguing with a socialistic government and, therefore, it is safe to assume that the majority of laboring men will never favor an entirely socialistic form of government.

Is there any reason to believe, if socialism in general will not be acceptable to the American citizen, that socialized American medicine will?

Socialized medicine abroad has been studied and most of the forms in use would not be acceptable to the American citizen. We are experiencing right now in this country a proof that the American citizen when he is able prefers to choose his own physician and hospital and pay for his service.

The all-inclusive British plan introduced in England by Sir William Beveridge will doubtless have its repercussions in this country. It is more than likely that a determined effort will be made to foist some such plan on our citizens on the grounds of war necessity.

Medical care in our country already has been socialized to a considerable extent. There are already as many hospital beds sup-

ported by government agencies as private. As a result of the war there is evidence of a tendency to increase rather than diminish the socialization of medicine. With the excuse of war emergency there is no telling what utopian plans may be suggested before the war is over. And after the war, what will be our economic status? It will require capital to provide new jobs for returning soldiers and high taxes will have to persist to pay interest on the already huge national debt. If the government is forced to supply the needed capital to furnish these new jobs, the transition from capitalism to socialism may be a simple matter. It will require a financial wizard in Washington to bridge the gap from war to peace economy.

For the medical profession to complacently sit back and oppose all change would be a mistake. To fail to resist complete socialization of medicine would be a betrayal of the American people. The profession should be and will be open minded in furthering plans proposed for the improvement of medical care at costs within reach of the public. The profession, as well as the public, are vitally interested in the preservation of capitalism, sometimes called the American way of life. Results of the recent elections indicate a reaction to the socialistic trends in our national government. A healthy state of affairs in the business world following the war will obviate any need for completely socializing medicine in America.

Editorial, *Minn. Med.*, March, 1943.

OBITUARY

TALEASIN H. DAVIES, M. D.

Dr. T. H. Davies died at the Delaware Hospital on March 25, 1943, on his 67th birthday anniversary. His death followed several years of poor health, and he had been seriously ill in the hospital for three weeks.

Born in Chicago, Dr. Davies was a son of the late John R. Davies, the second son of Lord Wadley, of Wadley, Wales. Dr. Davies graduated in medicine at the University of the South, Sewanee, Tenn., in 1898.

He came to Delaware in 1903 to accept the post of assistant superintendent of Delaware State Hospital under the late Dr. William H. Hancker.

In 1916, Dr. Davies left to become superintendent of Ferris Industrial School, but resigned after about a year and a half to resume private practice.

He was plant physician of a war factory in Maryland during the time the United States participated in World War I.

During World War I, Dr. Davies also served on the advisory board of the draft, and he was appointed to the board in this same capacity, as neurological and psychiatric consultant to the Selective Service Administration here, in World War II.

From 1923, when he was appointed by Mayor George W. K. Forrest, Dr. Davies was president of the Board of Health until last year, except for a two-year interval, during the administration of Dr. W. H. Speer.

For many years he was also a member of the State Board of Medical Examiners, retiring from that post two years ago.

Dr. Davies was secretary and later president of the New Castle County Medical Society, and a member of the Medical Society of Delaware and American Medical Association. He was also a member of Delaware Commission for the Mentally Defective, and Davies Cottage at Stockley Colony is named for him.

Dr. Davies was appointed a professor of neurology at Temple University, Philadelphia, by the late Dr. Russell Conwell, but resigned from that position many years ago because of the stress of duties here. At the time of his death he was chief neurologist at the Delaware Hospital, and consulting neurologist at the Delaware State and the Wilmington General Hospitals. He was an Episcopalean and a member of St. Andrew's Church.

Dr. Davies is survived by his wife, Mrs. Elizabeth Tudor-Davis Davies; one son, Taleasin H. Davies, Jr., of Nashua, N. H.; a granddaughter, Marie Delphine du Pont Davies; and three sisters, Mrs. John Garrett, Mrs. Howard Knapp, and Miss Edith Gwendolyn Davies, all of Duquesne, Pa.

The funeral was held on March 29th, with the Rev. John Ellis Large, rector of St. Andrew's P. E. Church, officiating. Burial was at Lower Brandywine Cemetery.

BOOK REVIEWS

Neurosurgery and Thoracic Surgery: Military Surgical Manuals Volume VI. Prepared and Edited by the Subcommittee on Neurosurgery and Thoracic Surgery of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Pp. 310, with 103 illustrations. Cloth. Price \$2.50. Philadelphia: W. B. Saunders Company, 1943.

This is the last of the six war surgical manuals, officially prepared for the armed services and published by Saunders. The present volume adheres to the original plan—short and authoritative texts on treatment, with diagnosis reduced to the minimum. In the services the treatment outlined is to be followed, unless the surgeon can justify a change, which will probably be a very infrequent occurrence. As a matter of fact, the civilian surgeon would do well to follow the advice given in these six volumes, since they represent the composite opinion of many of the nation's leaders in their respective subjects. As up-to-the-minute epitomes this is an exceedingly valuable set of books. The price is \$20.00 the set—money well spent.

Manual of Industrial Hygiene. William M. Gafafur, D. Sc., Editor. Cloth. Pp. 508. Price \$3.00. Philadelphia: W. B. Saunders Company, 1943.

While the stress of this book is on wartime conditions, the subtitle—Medical Service in War Industries—is hardly necessary, since the volume is devoted to the *principles* of industrial hygiene and industry during wartime is still industry. Or is it?

The book is prepared by the Division of Industrial Hygiene of the National Institute of Health of the United States Public Health Service, and 15 of the 16 contributors are with the P. H. S. The oleaginous references, somewhat too frequent, to this service, are annoying. Dr. Carlson's lecture in New York City on the "Newer Knowledge of Nutrition" (cf. review below: *The March of Medicine*) should be required reading for all Federal personnel, from the President on down!

Despite these strictures, however, the book is a good one, adequately covering the gamut of industrial hygienic science, and in a comparatively small space. Overlapping is reduced to a minimum; the style, while not terse, is not verbose; ample references are

included, and two-thirds of these are to non-governmental publications; and finally, the index seems to be sufficient. Altogether, this is a book that can be recommended.

The March of Medicine. The New York Academy of Medicine Lectures to the Laity. 1942. Pp. 217, with 11 illustrations. Cloth. Price \$2.50. New York: Columbia University Press, 1943.

Anyone, physician or layman, who would enjoy hearing a top-ranking medical expert talk about some phase of his special field will appreciate these essays, in which six authorities discuss, in simple but scientific terms, the background and recent developments of some vital problems of body and mind. Thoughtful readers will discern a common underlying implication: as man is a social being, individual welfare depends upon social progress.

The lectures and their authors are: (1) Tuberculosis: the Known and the Unknown, by James Miller; (2) The Brain and the Mind, by Tracy J. Putnam; (3) The Freudian Epoch, by Alton A. Brill; (4) Genius, Giftedness, and Growth, by Arnold Gesell; (5) The History of the B-Vitamins, by Norman Jolliffe; (6) The Newer Knowledge of Nutrition, by Anton J. Carlson.

We wish all the voters in the country, including the Washington high hats, the brass hats, and the no hats, could read this great debunking lecture by Dr. Carlson. Of the seven excellent and timely "Marches" that have so far appeared, we like this one the best.

Essentials of Proctology. Harry E. Bacon, M.D., Professor of Proctology, Temple University. Pp. 361, with 168 illustrations. Cloth. Price \$3.50. Philadelphia: J. B. Lippincott Company, 1943.

This is the best small treatise on the subject of proctology that has come to our notice. It is very easily read and is exceptionally well illustrated, which enhances its value to the general practitioner and to the general surgeon. One does not have to thumb through long text to find the meat. As a good quick reference work the book can be heartily recommended.

Clinical Diagnosis by Laboratory Methods. By James C. Todd, M. D., late Professor of Clinical Pathology, University of Colorado, School of Medicine; and Arthur H. Sanford, M. D., Professor of Clinical Pathology, University of Minnesota (The Mayo Foundation) Head of the Division of Clinical Laboratories, Mayo Clinic. 10th edition. Pp. 911, with 380 illustrations. Cloth. Price \$6.00. Philadelphia: W. B. Saunders Company, 1943.

A new edition of "Todd and Sanford" is always welcome. To quote the junior author, "It is thirty-four years since the appearance of the first edition of this book. Since that time clinical pathology has undergone marvelous development . . ." This 10th edition is visual tribute to the growth and recognition of clinical pathology as a specialty in medicine. As each year new methods are developed in the research laboratories, to be utilized in turn by clinical laboratories, the knowledge of a worker in this field must keep abreast of the newer procedures, while discarding the more obsolete ones.

There have been included in this edition, along with excellent illustrations, much new material. The determination of sulfonamides, the phosphatase method of King and Armstrong, a discussion of porphyrins in urine, and determinations of trypsin and amylase are among those included under clinical chemistry. The section on blood groups is excellent, and the importance and methods of testing for the Rh factor are considered. In the section on serology, techniques, as described by the originators of the methods, include those of Mazzine, Kline, Kahn, Huston, Eagle and Kolmer. The sections on hematology, urinalysis, gastric and duodenal contents, as always, are excellent. Especially important, in these days of global warfare, is the chapter on animal parasitology, with its bearing on tropical medicine. The section on microbiology, usually the weakest part of previous editions, is well revised, and includes some good photographs and illustrations of inclusion bodies, fluorescent staining of tubercle bacilli, diseases due to fungi, and the use of that important culture medium, Brewer's thioglycollate broth.

On the whole, this new edition will well

meet the needs of the teacher, student, medical technologist, and physician.

The Inner Ear, including Otoneurology, Otosurgery, and Problems in Modern Warfare. By Joseph Fischer, M. D., formerly Senior Otolaryngologist, Policlinic of Vienna; and Louis E. Wolfson, M. D., Instructor in Ear, Nose and Throat, Tufts Medical School. Pp. 421, with 79 illustrations. Cloth. Price \$5.75. New York: Grune & Stratton, Incorporated, 1943.

This book deals not only with the anatomy of the inner ear but also with its physiology, pathology, and neurology. It attempts to bridge the gap between the usual text books and the voluminous encyclopedias, and it does this very well indeed. The main attention is given to the labyrinth and its central pathways. Particular stress is placed on the pathologic anatomy of the various forms of labyrinthine disease. The book also lays stress on the fact that correct diagnosis and proper treatment depend on an exact knowledge of the pathologic basis. The last three chapters dealing with War Trauma, The Role of the Inner Ear in Aeronautics, and The Effects of Atmospheric Pressure Changes on the Ear are very interesting and of great importance to the physicians in the armed forces, especially those in the Air Corps. This book should be very helpful to post-graduate students of otolaryngology.

An Investigation of the Acuteness of Hearing of Children in the Delaware Public Schools by Means of the 4-A Audiometer (Phono-Audiometer). By Virginia S. Wallin, M. E., Psycho-Educational Examiner, Delaware Department of Public Instruction; and J. E. Wallace Wallin, Ph.D., Director of Special Education and Mental Hygiene, Delaware Department of Public Instruction and the Board of Public Education, Wilmington. Pp. 64. Paper. Price, 30 cents. Wilmington: Board of Education, 1942.

An elaborate statistical study, the gist of which is that the hard of hearing and the normal have the same basic intelligence, and that the former appear to rate lower mentally than they actually do. Partly a medical problem, the medical reports are too vague to have much value. The brochure will be of more interest to educators than to physicians.

